**Introduction**

- Insulin is a commonly prescribed medication for the treatment of Diabetes Mellitus.
- 2.8 million people in the UK have been diagnosed with diabetes. 10% of these patients have type 1 diabetes, all of whom receive insulin therapy.\(^1\)
- A significant number of type 2 diabetics are also prescribed insulin.
- Errors in the delivery of insulin are likely to cause harm due to its narrow therapeutic range.\(^2\)
- Despite the dangers associated with errors in insulin administration, dosing is commonly incorrect.
- The National Patient Safety Agency received 3,881 wrong dose insulin reports between 2003 and 2009. This included one death due to a 10 fold dosing error.\(^3\)

**Aim**

To investigate the incidence of transcribing errors in the prescription of insulin by clinicians in secondary care diabetes clinics at University Hospitals Birmingham.

**Methods**

- The medical records of 97 patients attending diabetes clinics between 27\(^{th}\) January 2011 and 10\(^{th}\) March 2011 were analysed.
- Patients not receiving insulin therapy were excluded, leaving 80 patients.
- The age, gender and number, type and dose of insulin were recorded from the clinic notes.
- At a later date, the Diabetes Clinic letters were analysed using the online computer system Clinical Portal and the insulin details recorded was compared to what was originally written in the clinic notes.
- Any discrepancies between the dose prescribed by the clinician and the dose recorded in the letter were noted.

**Results**

- Transcribing errors occurred in 20% of insulin prescriptions in our study sample.
- Transcribing errors are twice as common in patients on double insulin therapy.

**Conclusions**

- Transcribing errors occurred in 20% of insulin prescriptions in our study sample.
- Transcribing errors are twice as common in patients on double insulin therapy.

**Recommendations**

- Greater care needs to be taken when dictating letters to avoid insulin errors (see figure 4).
- Particular care needs to be taken with commonly confused digits such as 16 and 60.
- Special attention should be taken with patients on multiple insulin therapy.
- Letters should be thoroughly checked before being sent to the patient’s GP.

**Limitations**

This study only examines the incidence of errors in letters sent to patients’ General Practitioners. It does not investigate whether these errors translate into the patient administering the incorrect dose.

**References**


**Figure 1: Proportion of transcribing errors in patients on Insulin.**

**Figure 2: Quantity of errors increases with double insulin therapy.**

**Figure 3: Incorrect insulin doses are the commonest form of error.**

**Figure 4: Examples of errors**